

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

## DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-040444

STATE FILE NUMBER

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 163 Primary Registration District No. 3031 Registrar's No. 68

VS 300  
Rev. 4/59

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AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

DATE AMENDED

INSTEAD OF

SHOULD READ

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

1. PLACE OF BIRTH a. COUNTY Jefferson b. CITY (If outside corporate limits, give TOWNSHIP only) OR TOWN DeSoto c. FULL NAME OF (If NOT in hospital, give location) HOSPITAL OR INSTITUTION 608 No. Third St.		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Mo. b. COUNTY Jefferson c. CITY OR TOWN DeSoto d. STREET ADDRESS (If outside, give location) 377 Clark St.	
3. NAME OF DECEASED (Type or print) First Middle Last Pearl Ann Williams		4. DATE OF DEATH Month Day Year Oct. 15 1963	
5. SEX F	6. COLOR OR RACE W	7. Married <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>	8. DATE OF BIRTH 3/12/89
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic		10b. KIND OF BUSINESS OR INDUSTRY Housework	11. BIRTHPLACE (City and state or country) Hillsboro, Mo.
13a. FATHER'S NAME Edw. Williams		13b. MOTHER'S MAIDEN NAME Mamie Mallory	14. NAME OF HUSBAND OR WIFE None
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		17. INFORMANT Address 4471 Olive St. St. Louis, Mo. A Grace Farrar-	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Stomach DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a) PART III. If deceased was female was there a pregnancy in last 90 days. <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			INTERVAL BETWEEN DEATH AND DEATH
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	20a. ACCIDENT <input type="checkbox"/> SUICIDE <input type="checkbox"/> HOMICIDE <input type="checkbox"/>	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)	
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year	20d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		
20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)		20f. CITY, TOWN, OR LOCATION COUNTY STATE	
21. I attended the deceased from 2-26-63 to 10-15-63 and last saw her alive on 9-30-63 Death occurred at 10 20 p.m. on the date stated above, and to the best of my knowledge, from the causes stated.			
22a. SIGNATURE (Doctor or title) Has E. Faller M.D.		22b. ADDRESS DeSoto Mo.	22c. DATE SIGNED 10/17/63
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE 10/18/63	23c. NAME OF CEMETERY OR CREMATORY City	23d. LOCATION (City, town, or county) (State) DeSoto, Mo.
24. FUNERAL DIRECTOR ADDRESS J. L. Mothershead, DeSoto, Mo.		25. DATE RECD. BY LOCAL REG. 10-18-1963	26. REGISTRAR'S SIGNATURE Marie Farrar

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK  
OR  
TYPEWRITER RIBBON

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,

or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_

working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*J. Lee Mathershead*

Licensed Embalmer No. 3531

P. O. Address De Soto, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.